

FILED JAN 8 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 43405

BIRTH NO. _____		REG. DIST. NO. 360		PRIMARY REG. DIST. NO. 6225		Registrar's No. 141	
1. PLACE OF DEATH a. COUNTY <u>Vernon</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Lauderdale</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Rural Washburn</u>		c. LENGTH OF STAY (in this place) <u>6-5-27</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Washburn</u>		1551	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hosp #3</u>				d. STREET ADDRESS (If rural, give location) <u>✓</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>ROBERT LEE</u> b. (Middle) <u>PARNELL</u> c. (Last) _____				4. DATE OF DEATH (Month) <u>12</u> (Day) <u>27</u> (Year) <u>1950</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED <u>Married</u>		8. DATE OF BIRTH <u>Jan 24-76</u>	
9. AGE (In years last birthday) <u>74</u>		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>3</u>		11. IF UNDER 1 HRS. Hours <u>3</u> Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labourer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>		11. BIRTHPLACE (State or foreign country) <u>Saline Co Mo</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13a. FATHER'S NAME <u>Raymond Parnell</u>				13b. MOTHER'S MAIDEN NAME <u>Amanda Pettit</u>		14. NAME OF HUSBAND OR WIFE <u>Rosa Parnell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service) _____				16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Harold Parnell</u> ADDRESS <u>Neval</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerotic heart disease</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Pulmonary T.B.</u> DUE TO (c) <u>✓</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>✓</u> INTERVAL BETWEEN ONSET AND DEATH <u>002X</u>			
19a. DATE OF OPERATION <u>None</u>				19b. MAJOR FINDINGS OF OPERATION _____			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____				21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____			
21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____							
21d. TIME OF INJURY (Month) _____ (Day) _____ (Year) _____ (Hour) _____ (Min) _____				21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
21f. HOW DID INJURY OCCUR? _____							
22. I hereby certify that I attended the deceased from <u>6-27</u> , 19 <u>48</u> , to <u>12-27</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>12-27</u> , 19 <u>50</u> , and that death occurred at <u>2-10 am.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>R. S. Hall</u> (Degree or title) _____				23b. ADDRESS <u>Neval</u>			
23c. DATE SIGNED <u>12-27-50</u>							
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>12-27-1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Shelburne</u>		24d. LOCATION (City, town, or county) (State) <u>8 mi. N. Miller Mo</u>	
DATE REC'D BY LOCAL REG. <u>Dec. 27, 50</u>		REGISTRAR'S SIGNATURE <u>Kathryn H. Yancey</u> 331		25. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin Luman</u> ADDRESS <u>Miller Mo</u>			
(Licensed Embalmer's Statement on Reverse Side)							

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**DIVISION OF HEALTH OF MO.**

District No. 5 - Springfield

RECEIVED JAN 3 1951

Dist. File 151-28

Date Filed 1-4-51

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed E. R. Lemmon

Licensed Embalmer No. 3297

P. O. Address Miller Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.